



**North Carolina Department of Health and Human Services
Division of Medical Assistance
Finance Management
1985 Umstead Drive - 2501 Mail Service Center - Raleigh, N.C. 27699-2501
Courier Number 56-20-06**

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Gary Fuquay, Acting Director

**STATEMENT DUE DATE: March 15, 2004
Monthly Assessment Fee Statement**

Nursing Facility Name: ①
Provider Number: ②
Federal Tax ID Number ③

Please complete and return this form along with your monthly fee payment to the address below. It is imperative that you complete all data fields on this statement. Failure to submit the completed provider fee report and full payment by the due date shall result in penalties and interest as stated in the North Carolina Provider Agreement and Controller Cash Management Plan. Retain the top (white) copy for your records. If you should have any questions regarding this form or the reporting requirements, please contact DMA Nursing Home Rate Setting staff at (919) 857-4015.

Please Make Check Payable to:
Division of Medical Assistance

Mailing Address:
DHHS Accounts Receivable
325 N. Salisbury Street
2022 Mail Service Center
Raleigh, NC 27699-2022

Provider Assessment Worksheet - February

| | Current Month Ended Total | Documented Prior Period Adjustments | Adjusted Monthly Total | Year to Date Cumulative |
|---|---------------------------------|---|------------------------------|----------------------------|
| A Total Medicaid Patient Days | <u>④</u> | <u>⑨</u> | <u>⑭</u> | <u>⑳</u> |
| B Total Private / Other Non Medicare Days | <u>⑤</u> | <u>⑩</u> | <u>⑮</u> | <u>㉑</u> |
| C Total Non - Medicare Days (A+B) | <u>⑥</u> | <u>⑪</u> | <u>⑯</u> | <u>㉒</u> |
| D Provider Assessment Daily Rate | | | * <u>⑰</u> | |
| E Monthly Provider Fee Due (C*D) | | | <u>⑱</u> | |
| F Total Medicare Patient Days | <u>⑦</u> | <u>⑫</u> | <u>⑲</u> | <u>㉓</u> |
| G Total Patient Days (C + F) | <u>⑧</u> | <u>⑬</u> | <u>㉔</u> | <u>㉕</u> |

Signed By: ⑳, Title ㉖
(Must Be Owner, Partner, Officer or Administrator)

Print Name: ㉗, Telephone/Email ㉙

White - Financial Management Copy * Do Not Remove
Green - Controller's Office Copy * Do Not Remove
Canary - Provider's Copy * Retain Before Sending